Introduction

For plan years beginning on or after January 1, 2014, the Affordable Care Act (ACA) prohibits variation in rates for a given plan except variations based on (1) whether the plan covers an individual or family, (2) the rating area, (3) age, and (4) tobacco use. This paper addresses issues for states with respect to the second of these four factors. These issues include:

- How should the state define the rating areas?
- What restrictions, if any, should be placed on the issuer’s choice of area factors for rating purposes?

It should be noted that at the time of this writing, market reform rules have been proposed by CMS but have not been finalized.

Definition of Rating Areas

Legal Framework

PHSA § 2701(a)(2), as enacted by the ACA provides:

(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

In a rule proposed on November 20, 2012, CMS included further detail:

(b) Rating area. (1) A state may establish rating areas within that state for purposes of applying this section and the requirements of title XXVII the Public Health Service Act and title I of the Patient Protection and Affordable Care Act. A state that establishes rating areas shall submit to CMS information on its rating areas in accordance with the date and format specified by CMS.
(2) If a state's rating areas are not consistent with paragraph (b)(3) of this section, or if a state does not establish rating areas, the standard under paragraph (b)(3)(i) of this section shall apply unless CMS establishes rating areas within the state applying one of the standards under paragraph (b)(3)(ii) of this section.
(3) A state’s rating areas will be presumed adequate if one of the following requirements

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1 PHSA § 2701(a)(1)(A)
are met:

(i) There is only one rating area within the state.
(ii) There are no more than seven rating areas based on the one of the following geographic divisions: counties, three-digit zip codes, or metropolitan statistical areas/nonmetropolitan statistical areas.

(4) Notwithstanding paragraph (b)(3) of this section, a state may propose to CMS for approval other existing geographic divisions on which to base rating areas or a number of rating areas greater than seven.

These rating areas would apply equally to all non-grandfathered coverage in the individual or small group market, inside or outside of an Exchange.

There are no specifics in the proposed rules regarding modification of the rating area designation for plan years after 2014, if states wish to do so in light of changes in local utilization and costs patterns, issuer services areas, or MSA designation, etc.

CMS has requested comments on these provisions and the final rule may differ. Based on the final rule, states will be required to “submit relevant information on their rating areas to CMS within 30 days after the publication of the final rule.” The process, criteria, and timeline for HHS review is currently unclear.

Considerations for States

While a state could choose not to act and let the Secretary establish the rating areas, most states will likely prefer to retain control of this decision. The recently released proposed rule regarding rating areas allows for a state to select one of 3 approved standards, which would be presumed to be adequate by HHS. The 3 standards are: (1) one rating area for the entire state; (2) rating areas based on counties or 3-digit zip codes, but not both; or (3) rating areas based on MSAs and non-MSAs. If a state chooses either option (2) or (3), the maximum number proposed is seven. A state may propose for HHS’s consideration a different standard and/or more than seven areas.

Some states may opt for a single statewide rating area. This would be more feasible in a state where cost variations among parts of the state are small. In states with wide cost variations by area, the use of a single statewide rating area could be problematic. An insurer operating statewide would be at a competitive disadvantage against an insurer with business concentrated in lower-cost areas. This could result in some insurers choosing to focus only on higher-cost areas, while others focus on lower-cost areas. The result would be de facto rate variations by area, which would thwart the intent of the single statewide rating area.

Those in lower-cost areas and the legislators representing them may object to a single statewide rating area as unfair because it could require them to subsidize those in higher-cost areas. However, fairness is to a large degree in the eye of the beholder. Those in higher-cost areas may consider it unfair to pay higher rates because they feel they are not responsible for the higher
costs. Also, in at least some states, rural areas tend to be the higher cost areas\(^3\) and rural residents may be the least able to afford the extra cost due to lower incomes.

Conversely, establishing too many rating areas could also be problematic. If areas are too small, there may not be a credible basis for determining rating factors other than provider reimbursement arrangements. Also, there may be issues concerning discrimination if a small area is targeted for higher cost factors.

As a starting point, states will likely want to look at current practice. If the state already specifies rating areas, there is probably no reason to change the current structure. In states where insurers determine their own rating areas, the state may want to look at the current practice of the major insurers in the state. To the extent the major insurers use the same or similar rating areas, the state may want to base its rating areas on those. This could serve to minimize disruption when moving to new rating areas, but may disadvantage some insurers if their relative costs by geography do not align with the consolidation.

Other considerations include cost transparency. Mixing high and low cost areas within a single rating area, could mask delivery costs, potentially mitigating pressure on providers in high cost areas to lower their costs. Additionally, states should consider the interaction between service area and rating area. If service areas are smaller than rating areas, insurers may reduce their service areas to avoid high cost areas included in the same rating area as a lower cost area. This may be particularly disadvantageous to rural areas that may not have access to a competitive market.

**Determination of Area Rating Factors**

**Legal Framework**

Neither the ACA nor the proposed rules explicitly address the determination of area rating factors. Insurers often base their area factors on either their claims experience or provider reimbursement arrangements in each area. Differences in claims experience may reflect differences in several components, including provider charges and contracts, utilization patterns, the health status of enrollees, and the age of enrollees. It might be argued that reflecting differences in health status in area factors violates the ACA prohibitions on discrimination based on health status.\(^4\) It might also be argued that reflecting differences in age in area factors results in age variations in excess of the permitted 3:1 range.

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\(^3\) Reasons for higher costs in rural areas may include lack of economies of scale and lack of competition among providers. If there is only one hospital or one specialty practice of a particular type in the area, they may have little incentive to accept lower payment rates from insurers because the insurer need them in order to have an adequate provider network. Therefore the insurers may have little bargaining power in negotiating contracts.

\(^4\) PHS Act section 2705(b)(1) states, “A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly
Considerations for States

In the absence of any federal guidance to the contrary, states have the option to allow insurers to determine their own area factors. States that review rates would likely want to review the methodology used by the insurer to ensure that it is actuarially sound.

States could begin by including area factors, in addition to rating areas, in their review of current area rating practices. In order to make valid comparisons among carriers, one particular area (e.g., county, zip code, etc.) should be set at 1.00 for all carriers and the remaining factors rebased to this “anchor” area. This may reveal a good deal of commonality among carriers with respect to what areas are considered high and low cost, even after consideration of varying provider agreements. This will also serve to minimize disruption, should a State decide to establish area factors along with the rating areas. There may be cases, however, where there is not a lot of commonality across carriers due to provider contracting and competitive differences across geography within a state. If this is the case, consolidating rating areas could reduce competition in certain service areas and create winners and losers across carriers.

Alternatively, the state may want to limit either the methodology used or the range of the resulting area factors.

Methodology: The state may want to specify what factors can and cannot be reflected in area factors. The following are factors that would typically affect area factors if permitted by the state:

- **Price.** Differences from one area to another in prices paid by the insurer for services are generally considered an appropriate consideration in determining area factors. Price differences may be reflected explicitly or they may be reflected implicitly by basing area factors on claim costs per member per month. If reflected explicitly, the basis would typically be differences in provider contracts. If providers in one area have agreed to lower reimbursement than in another area, reflecting this in the area factor gives the benefit of the lower costs to policyholders in that area. For indemnity plans, where the insurer does not contract with providers, usual and customary fees may be used instead.

- **Utilization.** Differences in utilization from one area to another may be reflected explicitly or they may be reflected implicitly by basing area factors on claim costs per member per month. Differences in utilization may in turn reflect differences in practice patterns, in the availability of providers, in health status, or in age. As noted above, differences based on health status or age could be considered contrary to the intent of the ACA. Although the proposed rules do not make that interpretation, states may choose to restrict the use of these factors for policy reasons.

situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.
Alternatively, the state could specify area factors that all insurers must use. However, differences in provider contracts may vary by insurer and these variations would not be reflected in premiums if the state sets uniform area factors.

**Range.** According to an NAIC issue brief entitled “Rate Regulation,” states often regulate insurers’ use of rating factors through rate banding to preserve “the pooling of risk between low-cost and high-cost individuals, [which is] the core function of insurance...” ⁵ There may be geographic rating restrictions in a state “depending on the variation in medical costs within the state and range from no variation in the District of Columbia to around 2.1:1 in Florida.” ⁶ Current Maine law, for example, restricts geographic area rating factors to a 1.5 to 1 rating band in the individual and small group markets; therefore, if the lowest factor a carrier uses is 0.85, then the highest allowable factor would be 1.275, which is 1.5 times 0.85. While states may wish to reexamine their past decisions to limit or not limit the range, it is not clear that the 2014 market changes resulting from the ACA would have any bearing on that decision. On the other hand, since several rating variables currently allowed in many states will not be permitted, it may be desirable to have as much precision and flexibility in the few rating variables that remain. States that do not currently have rating restrictions by geographic area may consider possible rate caps, or other phase-in mechanisms, to mitigate the potential consumer rate shock due solely to the creation of new rating areas.

**Conclusion**

The proposed market reform rule allows states some discretion in determining rating areas and regulating (or not regulating) area rating factors. If a state does not specify rating areas, CMS will do so. The proposed rule does not restrict the methodology used to determine area factors nor the states’ ability to regulate the methodology or the range of area factors.

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⁵ [http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf](http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf)